

APPENDIX B-1**CLAIM PREPARATION AND MAILING INSTRUCTIONS FOR
FORM DPA 1443, PROVIDER INVOICE**

Please follow these guidelines in the preparation of claims for imaging processing to assure the most efficient processing by the Department:

- Claims that are illegible will be returned to the provider.
- Claims with extreme print qualities, either light or dark, will not image.
- Use only one font style on a claim. Do not use bold print, italics, script, or any font that has connecting characters.
- Do not use punctuation marks, slashes, dashes or any special characters anywhere on the form.
- Claims should be typed or computer-printed in capital letters. The character pitch must be 10-12 printed characters per inch, the size of most standard pica or elite typewriters. Handwritten entries should be avoided.
- All entries must be within the specified boxes. Do not write in the margins.
- Red ink does not image. Use only black ink for entries on the billing form, attachments and provider signature.
- If corrections need to be made, reprinting the claim is preferred. Correction fluid should be used sparingly.
- Remove the pin-feed strips on claims at the perforations only. Do not cut the strips, as it may alter the document size.
- Attachments containing a black border as a result of photocopying with the copier cover open cannot be imaged. Attachments must have a minimum one-half inch white border at the top and on the sides to ensure proper imaging of the document.
- For attachments containing gray areas, either as a part of the original or as a result of photo-copying a colored background, print in the gray area is likely to be unreadable. If information in this area is important, the document should be recopied to eliminate the graying effect as much as possible without making the print too light.
- Attachments should be paper-clipped or rubber-banded to claims. Do not fold invoices or fasten attachments with staples.

Appendix B-1a is a copy of Form DPA 1443, Provider Invoice. Instructions for completion of the Provider Invoice follow in the order entries appear on the form. Mailing instructions follow the claim preparation instructions.

The left hand column of the following instructions identifies mandatory and optional items for form completion as follows:

| | |
|-------------------------------|---|
| Required | = Entry always required. |
| Optional | = Entry optional - In some cases failure to include an entry will result in certain assumptions by the Department and will preclude corrections of certain claiming errors by the Department. |
| Conditionally Required | = Entries which are required only under certain circumstances. Conditions of the requirement are identified in the instruction text. |
| Not Required | = Fields not applicable to the provision of chiropractic services. |

COMPLETION**ITEM EXPLANATION AND INSTRUCTIONS**

- | | |
|-------------------------------|--|
| Required | 1. Provider Name - Enter the chiropractor's name exactly as it appears on the Provider Information Sheet. |
| Required | 2. Provider Number - Enter the Provider Number exactly as it appears on the Provider Information Sheet. |
| Conditionally Required | 3. Payee - This entry is required when the chiropractor has more than one potential payee. Enter the one-digit code of the payee to whom payment is to be sent. Payees are coded numerically on the Provider Information Sheet. |

If no code is entered here, but the provider has designated more than one potential payee on the Provider Information Sheet, the claim will be rejected.

Not Required 4. **Group** - Leave blank.

Not Required 5. **Role** - Leave blank.

**Conditionally
Required**

6. **Acc/Inj** - This is a one-digit numeric field. When applicable, enter one of the following Accident/Injury Codes to indicate the probable reason the participant sought treatment.

1 - Employment - The patient's injury is due to a work related accident or illness.

2 - Motor Vehicle - The patient's injury was received while operating a motor vehicle or as a passenger in a motor vehicle, or another type of accident involving a motor vehicle.

3 - Athletic - The patient's injury is due to participation in an organized sport or school activity.

4 - Victim - The patient's injury is due to an act of violence (non-accidental).

5 - Other - The patient's injury is the result of an unspecified accident.

Optional

7. **Provider Reference** - Enter up to 10 numbers or letters used in the chiropractor's accounting system for identification. If this field is completed, the same data will appear on Form DPA 194-M-1, Remittance Advice, returned to the chiropractor.

Optional

8. **Provider Street** - Enter the street address of the chiropractor's primary office. If the address is entered, the Department will, where possible, correct claims suspended due to provider eligibility errors. If the address is not entered, the Department will not attempt corrections.

**Conditionally
Required**

9. **Facility & City Where Service Rendered** - This entry is required when Place of Service Code in Field 28 (Service Sections) is other than A (provider's office) or K (patient's home).

Not Required

10. **Prior Approval** - Leave blank..

Optional

11. **Provider City State Zip** - Enter city, state and zip code of provider. See Item 8 above.

Not Required

12. **Referring Practitioner Name** - Leave blank.

- | | |
|-----------------|---|
| Not Required | 13. Ref. Prac. No. - Leave blank. |
| Required | 14. Recipient Name - Enter the patient's name exactly as it appears on the MediPlan Card, Temporary MediPlan Card or KidCare Card. Separate the components of the name (first, middle initial, last) in the proper sections of the name field. |
| Required | 15. Recipient No. - Enter the nine-digit number assigned to the individual as copied from the MediPlan Card or Temporary MediPlan or KidCare Card. Use no punctuation or spaces. Do not use the Case Identification Number. If the Temporary MediPlan Card does not contain the recipient number, enter the patient name and birth date on the Provider Invoice and attach a copy of the Temporary MediPlan Card to the Provider Invoice. The Department will review the claim and determine the correct recipient number. See "Mailing Instructions" in this Appendix when a copy of the Temporary MediPlan Card is attached. |
| Required | 16. Birth date - Enter the month, day and year of birth of the patient as shown on the MediPlan Card, Temporary MediPlan Card or KidCare Card. Use the MMDDYY format. |
| Not Required | 17. Healthy Kids - Leave blank. |
| Not Required | 18. Fam Plan - Leave blank. |
| Not Required | 19. Cr. Child - Leave blank. |
| Not Required | 20. St/Ab - Leave blank. |
| Required | 21. Billing Date - Enter the date the Provider Invoice was prepared. Use MMDDYY format. |
| Optional | 22. Primary Diagnosis - Enter the primary diagnosis which describes the condition primarily responsible for the patient's treatment. |
| Required | 23. Prefix - If the ICD 9-CM code identifying the diagnosis listed in item 22 has a prefix, enter the prefix. |
| Required | 24. Diag. Code - Enter the appropriate ICD 9-CM code identifying the condition primarily responsible for the patient's treatment. |

| | | | | | | | | | | | |
|-------------------------------|--|--------------|--------------------------|---|-------------------|---|-------------------------|---|-------------------------|---|----------------|
| Required | 25. Secondary Diagnosis - Enter the diagnosis when treatment is the result of a condition different than the patient's primary condition. | | | | | | | | | | |
| Required | 26. Prefix - If the ICD 9-CM code identifying the diagnosis listed in item 25 has a prefix, enter the prefix. | | | | | | | | | | |
| Required | 27. Diag. Code - If a secondary diagnosis is identified in item 25, enter the appropriate ICD 9-CM code identifying that diagnosis. | | | | | | | | | | |
| Required | 28. Service Sections: Complete one service section for each service provided to the patient. | | | | | | | | | | |
| Conditionally Required | Procedure Description/Drug Name - Enter the appropriate description of the service provided. | | | | | | | | | | |
| Required | Proc. Code/Drug Item No. - Enter the appropriate five-digit procedure code as specified in this handbook. See section B-203. | | | | | | | | | | |
| Conditionally Required | Delete - When an error has been made that cannot be corrected enter an "X" to delete the entire service section. Only "X" will be recognized as a valid character; all others will be ignored. | | | | | | | | | | |
| Required | Date of Service - Enter the date the service was performed. Use MMDDYY format. | | | | | | | | | | |
| Required | Cat. Serv. - Enter the appropriate Category of Service code. | | | | | | | | | | |
| | 05 - Chiropractic Services | | | | | | | | | | |
| Required | Place of Serv. - Enter the one letter Place of Service code from the following list: | | | | | | | | | | |
| | <table> <tr> <td>Code:</td><td>Place of Service:</td></tr> <tr> <td>A</td><td>Provider's Office</td></tr> <tr> <td>H</td><td>Long Term Care Facility</td></tr> <tr> <td>I</td><td>Sheltered Care Facility</td></tr> <tr> <td>K</td><td>Patient's Home</td></tr> </table> | Code: | Place of Service: | A | Provider's Office | H | Long Term Care Facility | I | Sheltered Care Facility | K | Patient's Home |
| Code: | Place of Service: | | | | | | | | | | |
| A | Provider's Office | | | | | | | | | | |
| H | Long Term Care Facility | | | | | | | | | | |
| I | Sheltered Care Facility | | | | | | | | | | |
| K | Patient's Home | | | | | | | | | | |
| Not Required | Units/Quantity - Leave blank. | | | | | | | | | | |
| Not Required | Modifying Units - Leave blank. | | | | | | | | | | |

**Conditionally
Required**

TPL Code - If the patient's MediPlan or KidCare Card contains a TPL code, the code is to be entered in this field. If the patient has a TPL resource that is not shown on the MediPlan or KidCare Card, refer to Chapter 100, General Appendix 9 for the list of TPL Referencing Codes and enter in this field. If the TPL Resource Codes are not appropriate enter 999 and enter the name of the payment source in the Uncoded TPL Name field.

**Conditionally
Required**

Status - If a TPL code is shown in the previous item, a two-digit code indicating the disposition of the third party claim must be entered. No entry is required if the TPL code is 000 or blank.

The TPL Status Codes are:

01 - TPL Adjudicated - total payment shown - TPL Status Code 01 is to be entered when payment has been received from the patient's third party resource or the participant has a spenddown liability. The amount of payment received or the spenddown liability **must** be entered in the TPL amount box.

02 - TPL Adjudicated - patient not covered - TPL Status Code 02 is to be entered when the provider is advised by the third party resource that the patient was not insured at the time services were provided.

03 - TPL Adjudicated - services not covered - TPL Status Code 03 is to be entered when the provider is advised by the third party resource that services provided are not covered.

04 - TPL Adjudicated - spenddown met - TPL status code 04 is to be entered when the patient's Form DPA 2432, Split Billing, shows \$0.00 liability.

When the date of service is the same as the "Spenddown Met" date on the DPA 2432, Split Billing Transmittal, attach the DPA 2432 to the invoice. The split bill transmittal supplies the information necessary to complete the TPL fields.

If Form DPA 2432, Split Billing Form Transmittal, shows a recipient liability greater than \$0.00 the invoice should be coded as follows:

| | |
|------------|--|
| TPL Code | 906 |
| TPL Status | 01 |
| TPL Amount | The actual recipient liability as shown on DPA Form 2432. |
| TPL Date | The issuance date on the bottom right corner of the DPA Form 2432. This is in MMDDYY format. |

If Form DPA 2432, Split Billing Transmittal, shows a recipient liability of \$0.00 the invoice should be coded as follows:

| | |
|------------|---|
| TPL Code | 906 |
| TPL Status | 04 |
| TPL Amount | 0 00 |
| TPL Date | The issuance date on the bottom right corner of the DPA 2432. This is in MMDDYY format. |

05 - Patient not covered - TPL Status Code 05 is to be entered when a patient informs the provider that the third party resource identified on the MediPlan Card is not in force.

06 - Services not covered - TPL Status Code 06 is to be entered when the provider determines that the identified resource is not applicable to the service provided.

07 - Third Party Adjudication Pending - TPL Status Code 07 may be entered when a claim has been submitted to the third party, 60 days have elapsed since the third party was billed, and reasonable follow-up efforts to obtain payment have failed.

10 - Deductible not met - TPL Status Code 10 is to be entered when the provider has been informed by the third party resource that non-payment of the service was because the deductible was not met.

**Conditionally
Required**

TPL Amount - Enter the amount of payment received from the third party health resource. A dollar amount entry is required if TPL Status Code 01 was entered in the "Status" box. If there is no TPL code, no entry is required.

**Conditionally
Required**

Adjudication Date - A TPL date is required when any status code is shown in Item 28J. Use the date specified below for the applicable code:

Code Date to be entered

- 01** - Third Party Adjudication Date
- 02** - Third Party Adjudication Date
- 03** - Third Party Adjudication Date
- 04** - Date from the DPA 2432
- 05** - Date of Service
- 06** - Date of Service
- 07** - Date of Service
- 10** - Third Party Adjudication Date

Required

Provider Charge - Enter the total charge for the service, not deducting any TPL.

Not Required

Repeat - Leave blank.

Not Required

29. Optical Materials Only - Leave blank.

Charges and Deductions Section (Unlabeled) - The information field in the lower right of the Provider Invoice is to be used: 1) to identify additional third party resources in instances where the patient has access to two or more resources and 2) to calculate total and net charges.

If a second third party resource was identified for one or more of the services billed in service sections 1 through 7 of the Provider Invoice, complete the TPL fields in accordance with the following instructions:

**Conditionally
Required**

Sect. # - If more than one third party made a payment for a particular service, enter the service section number (1 through 7) in which that service is reported.

If a third party resource made a single payment for several services and did not specify the amount applicable to each, enter the number 0 (zero) in this field. When 0 is entered, the third party payment shown in section 30 will be applied to the total of all service sections on the Provider Invoice.

**Conditionally
Required**

TPL Code - Enter the appropriate TPL Resource Code referencing the source of payment (General Appendix 9). If the TPL Resource Codes are not appropriate enter 999 and enter the name of the payment source in the Uncoded TPL Name field.

**Conditionally
Required**

Status - Enter the appropriate TPL Status Code. See the Status field in Item 28 above for correct coding of this field.

**Conditionally
Required**

TPL Amount - Enter the amount of payment received from the third party resource.

Optional

Adjudication Date - Enter the date the claim was adjudicated by the third party resource. (See the Adjudication Date field in Item 28 above for correct coding of this field.)

**Conditionally
Required**

Uncoded TPL Name - Enter the name of the third party health resource. The name must be entered if TPL code 999 is used.

Claim Summary Fields: The three claim summary fields must be completed on all Provider Invoices. These fields are Total Charge, Total Deductions and Net Charge. They are located at the bottom far right of the form.

Required

Total Charge - Enter the sum of all charges submitted on the Provider Invoice in service section 1 through 7.

Required

Total Deductions - Enter the sum of all payments received from other sources. If no payment was received, enter three zeroes (000).

| | |
|-----------------|---|
| Required | Net Charge - Enter the difference between Total Charge and Total Deductions. |
| Required | 31. # Sects - Enter the total number of service sections completed correctly in the top part of the form. This entry must be at least one and no more than 7. Do not count any sections which were deleted because of errors. |
| Not Required | 32. Original DCN - Leave blank. |
| Not Required | 33. Original Voucher Number - Leave blank. |
| Required | Provider Certification, Signature and Date - After reading the certification statement, the provider must sign the completed form. The signature must be handwritten in black or dark blue ink. A stamped or facsimile signature and unsigned Provider Invoices will be rejected. The signature date is to be entered. |

MAILING INSTRUCTIONS

The Provider Invoice is a two-part form. The provider is to submit the original to the Department as indicated below. The copy of the claim is to be retained by the provider.

The pin-feed guide strip must be detached from the sides of continuous feed forms.

Routine claims are to be mailed to the Department in pre-addressed mailing envelopes, Form DPA 1444, Provider Invoice Envelope, provided by the Department.

Non-routine claims are to be mailed to the Department in pre-addressed mailing envelope, Form DPA 2248, Special Handling Envelope, which is provided by the Department for this purpose. A non-routine claim is one to which one or more of the following documents are attached:

- Form DPA 1411, Temporary MediPlan Card
- Form DPA 2432, Split Billing Transmittal

APPENDIX B-1a

Reduced Facsimile of Form DPA 1443, Provider Invoice

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|----------------------|--|---------------|--|--------------|--|-----------------|--|----------|--|------------------|--|--------------|--|-------------------|--|-------------------|--|-----------------------|--|--------------------|--|--|--|--|--|--|--|--|--|
| PROVIDER INVOICE ILLINOIS DEPARTMENT OF PUBLIC AID | | | | | | | | | | IDPA USE ONLY | | | | | | | | | | | | | | | | | | | | | | | | |
| ELITE <input type="checkbox"/> <input type="checkbox"/> PICA <input type="checkbox"/> <input type="checkbox"/> | | TYPEWRITER ALIGNMENT ←-----USE CAPITAL LETTERS ONLY-----→ | | | | | | | | | | | | | | | | | | ELITE <input type="checkbox"/> <input type="checkbox"/> PICA <input type="checkbox"/> <input type="checkbox"/> | | | | | | | | | | | | | | |
| | | | | | | | | | | NNN | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. PROVIDER NAME (First, Last) | | | | | | | | | | 2. Provider Number | | | | | 3. Payee | | 4. Group | | 5. Role | | 6. Acc/Inj | | 7. Provider Reference | | | | | | | | | | | |
| 8. Provider Street | | | | | | | | | | 9. Facility and City Where Service Rendered | | | | | | | | | | | | | | | 10. Prior Approval | | | | | | | | | |
| 11. Provider City | | | | | | | | | | 12. Referring Practitioner Name (First, Last) | | | | | | | | | | | | | | | 13. Ref. Prac. No. | | | | | | | | | |
| 14. Recipient Name, (First, MI, Last) | | | | | 15. Recipient Number | | | | | 16. Birthdate | | | | | 17. H Kids | | 18. Fam Plar | | 19. Cr Child | | 20. St/Ab | | 21. Billing Date | | | | | | | | | | | |
| 22. Primary Diagnosis | | | | | | | | | | | | | | | 23. Prefix | | | | | 24. Diag. Code | | | | | | | | | | | | | | |
| 25. Secondary Diagnosis | | | | | | | | | | | | | | | 26. Prefix | | | | | 27. Diag. Code | | | | | | | | | | | | | | |
| 28. Service Sections | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1 | | | | | | | | | | Procedure Description / Drug Name, Form and Strength or Size | | | | | | | | | | Proc. Code/Drug Item No. | | | | | Delete | | | | | | | | | |
| Date of Service | | | | | Cat. Serv. | | Place of Serv | | Units/Quanti | | Modifying Units | | TPL Code | | Status | | TPL Amount | | Adjudication Date | | Provider Charge | | | | | | | | | | | | | |
| 2 | | | | | | | | | | Repeat <input type="checkbox"/> Procedure Description / Drug Name, Form and Strength or Size | | | | | | | | | | Proc. Code/Drug Item No. | | | | | Delete | | | | | | | | | |
| Date of Service | | | | | Cat. Serv. | | Place of Serv | | Units/Quanti | | Modifying Units | | TPL Code | | Status | | TPL Amount | | Adjudication Date | | Provider Charge | | | | | | | | | | | | | |
| Note: Center section of form has been removed to enlarge detail. The actual form has 7 Service Sections. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7 | | | | | | | | | | Repeat <input type="checkbox"/> Procedure Description / Drug Name, Form and Strength or Size | | | | | | | | | | Proc. Code/Drug Item No. | | | | | Delete | | | | | | | | | |
| Date of Service | | | | | Cat. Serv. | | Place of Serv | | Units/Quanti | | Modifying Units | | TPL Code | | Status | | TPL Amount | | Adjudication Date | | Provider Charge | | | | | | | | | | | | | |
| 29. OPTICAL MATERIALS ONLY | | | | | | | | | | Sec # | | | | | TPL Code | | Status | | TPL Amount | | Adjudication Date | | Total Charges | | | | | | | | | | | |
| | | | | | | | | | | Sec # | | | | | TPL Code | | Status | | TPL Amount | | Adjudication Date | | Total Deductions | | | | | | | | | | | |
| | | | | | | | | | | Sec # | | | | | TPL Code | | Status | | TPL Amount | | Adjudication Date | | Net Charges | | | | | | | | | | | |
| 31. # Sects | | | | | 32. Original DCN | | | | | 33. Orig Voucher # | | | | | Uncoded TPL Name | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <p>My signature certifies that: all entries on this claim are true, accurate and complete; the State's Medical Assistance Program pricing limits will be accepted as payment in full; any payments received from this patient or any other third party will be properly credited or paid to the Illinois Department of Public Aid; records necessary to fully disclose the nature and extent of services provided are maintained and will be made available upon request of State and Federal officials responsible for the various aspects of the State's Medical Assistance Program, as provided under Title XIX of the Social Security Act and applicable State statutes; I provided or directly supervised all services for which a charge appears; I understand payment is made from State and Federal funds and that any falsification or concealment of material fact may lead to appropriate legal action; in compliance with the Civil Rights Act of 1964, services were provided without discrimination on the grounds of race, color or national origin; and handicapped persons are afforded the rights and consideration specified in Section 504 of the Rehabilitation Act of 1973 and Part 84 of the Code of Federal Regulations.</p> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | Signature | | | | | | | | | | Date | | | | | | | | | |
| DPA 1443 (R-1-91) Completion mandatory, Ill. Rev. Stat., Ch. 23, P.A. Code, penalty non-payment. Form Approved by the Forms Management Center. IL478-1210 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

APPENDIX B-2

PREPARATION AND MAILING INSTRUCTIONS FOR MEDICARE/MEDICAID COMBINATION CLAIMS

Chapter 100, Topic 120.1 provides general guidance for claim submittal and payment when a patient is covered by both Medicare and Medicaid. These are generally referred to as combination claims. This Appendix provides detailed instructions for coding Medicare claims to facilitate proper consideration for payment of co-insurance and deductibles by the Department.

Coding and Submission of Claims to the Medicare Carrier or DMERC

Charges for services provided to covered participants who are also eligible for Medicare benefits must be submitted to the Medicare Carrier on Form HCFA 1500. The words "Illinois Department of Public Aid" or "IDPA" and the patient's nine-digit Recipient Identification Number are to be entered in Field 9a of the Form HCFA 1500. Field 27 must be marked "Yes", indicating the provider will accept assignment.

In many instances, this entry will cause the claim to "cross over", that is, the claim will be forwarded to the Department by the Medicare Carrier automatically, without any further action by the provider. This is referred to as a crossover claim. When a claim crosses over, the Explanation of Medicare Benefits (EOMB) will contain a message or code indicating that the claim has been sent to the Department. The claim will appear later on a Department Remittance Advice after it has been adjudicated.

Submission of Claims That Do Not Automatically Cross Over

For consideration of payment of the coinsurance and deductible, the provider must submit the claim directly to the Department when:

- payment is made by the Medicare Carrier but the EOMB does not show that the claim has been crossed over, or
- when more than 90 days has elapsed since the Medicare payment but the claim has not appeared on a Department Remittance Advice.

Submit a copy of Form HCFA 1500 with a copy of the Medicare EOMB or the Medicare payment voucher.

Prior to submitting the claim to the Department, the following additional information must be entered on Form HCFA 1500:

- the provider name in Field 33 exactly as it appears on the Provider Information Sheet,
- the provider's Provider Number in the lower right corner of Field 33, and

- the one-digit provider payee code (if the provider has multiple payees listed on the Provider Information Sheet) in Field 33 immediately following the Provider Name. If the HCFA 1500 submitted to Medicare lists services of two or more practitioners, a separate claim and EOMB is required for each. In addition, the services provided by each practitioner must be identified.

The disposition of the claim will be reported on the Department's Remittance Advice.

Provider Action on Services Totally Rejected by Medicare

The Department's liability for payment is generally based on Medicare's determination as to medical necessity and utilization limits. Before submitting a denied claim to the Department, the provider should review the reason for Medicare's denial to determine if submittal of the claim is indicated. In general, the provider should submit a claim to the Department for payment consideration only when the reason for Medicare's denial of payment is either:

- the patient was not eligible for Medicare benefits or
- the service is not covered as a Medicare benefit.

In such instances, the Department is to be billed only after final adjudication of the claims by the Medicare Carrier. If the provider has requested a reconsideration of Medicare's denial, the Department is not to be billed until after Medicare's reconsideration decision.


Claims which have been denied by Medicare for which the provider is seeking payment must be submitted on a Form DPA 1443, Provider Invoice, with a copy of the EOMB attached. If Medicare reconsideration was requested and denied, a copy of the reconsideration decision and any correspondence should also be attached.




APPENDIX B-3

EXPLANATION OF INFORMATION ON PROVIDER INFORMATION SHEET

The Provider Information Sheet is produced when a provider is enrolled in the Department's Medical Programs. It will also be generated when there is a change or update to the provider record. This sheet will then be mailed to the provider and will serve as a record of all the data that appears on the Provider Data Base.

If, after review, the provider notes that the Provider Information Sheet does not reflect accurate data, the provider is to line out the incorrect information, note the correct information, sign the document and return it to the Provider Participation Unit in Springfield, Illinois. (See Topic B-201.4 for instructions.) If all the information noted on the sheet is correct, the provider is to keep the document and reference it when completing any Department forms.

The following information will appear on the Provider Information Sheet. A sample of a Provider Information Sheet is attached as Appendix B-3a. The item or area numbers that correspond to the explanations below appear in small circles  on the sample form.

| FIELD | EXPLANATION |
|---|---|
|  PROVIDER KEY | This number uniquely identifies the provider and is to be used as the provider number when billing charges to the Department. |
|  PROVIDER NAME AND LOCATION | This area contains the NAME AND ADDRESS of the provider as carried in the Department's records. The three-digit COUNTY code identifies the county in which the provider maintains his primary office. It is also used to identify a state if the provider's primary office location is outside of Illinois. location. The TELEPHONE NUMBER is the primary telephone number of the provider's primary office. |
|  ENROLLMENT SPECIFICS | <p>This area contains basic information reflecting the manner in which the provider is enrolled with the Department.</p> <p>PROVIDER TYPE is a three-digit code and corresponding narrative which indicates the provider's classification.</p> |

ORGANIZATION TYPE is a two-digit code and corresponding narrative indicating the legal structure of the environment in which the provider primarily performs services. The possible codes are:

- 01 = Individual Practice
- 02 = Partnership
- 03 = Corporation

ENROLLMENT STATUS is a one-digit code and corresponding narrative which indicates whether or not the provider is currently an active participant in the Department's Medical Programs. The possible codes are:

- A = Active - Cost Reporting
 - B = Active - Non-cost Reporting
 - D = Inactive - Disenrollment
 - I = Inactive
 - L = Active - Limited Enrollment; Provider from Non-bordering state with claim for less than \$150.00
 - N = Non Participating; have not had a claim paid or rejected in previous 18 months.
 - W = Inactive - Uncollectible debt; provider owes the Department monies
- Disregard the term NOCST if it appears in this item.

Immediately following the enrollment status indicator are the **BEGIN** date indicating when the provider was most recently enrolled in the Department's Medical Programs and the **END** date indicating the end of the provider's most current enrollment period. If the provider is still actively enrolled, the word "ACTIVE" will appear in the **END** date field.

EXCEPTION INDICATOR may contain a one-digit code and corresponding narrative indicating that the provider's claims will be reviewed manually prior to payment. The possible codes are:

- A = Intent to terminate
- B = Expired License
- C = Citation to Discover Assets
- D = Delinquent Child Support
- E = Provider Review
- F = Fraud Investigations
- G = Garnishment

I = Indictment
L = Student Loan Suspensions
R = Intent to Terminate/Recovery
S = Exception Requested By Provider
Participation Unit
T = Tax Levy
X = Tax Suspensions

If this item is blank, the provider has no exception.

Immediately following the **EXCEPTION INDICATOR** are the **BEGIN** date indicating the first date when the provider's claims were to be manually reviewed and the **END** date indicating the last date the provider's claims were to be manually reviewed. If the provider has no exception, the date fields will be blank.

AGR (Agreement) indicates whether the provider has a form DPA 1413, Provider Agreement, on file and the provider is eligible to submit claims electronically. Possible entries are YES or NO.

4 **CERTIFICATION/**

This is a unique number identifying the license issued by a state agency authorizing a provider to practice or conduct business. This entry is followed by the **ENDING** date indicating when the license will expire.

5 **S.S.#**

This is the provider's social security or FEIN number.

6 **CATEGORIES
OF SERVICE**

This area identifies special licensure information and the types of services a provider is enrolled to provide.

ELIGIBILITY CATEGORY OF SERVICE contains a three-digit code and corresponding narrative indicating the type of service a provider is authorized to render to patients covered under the Department's Medical Programs. The proper code is:

05 = Chiropractic Services

This entry is followed by the date that the provider was approved to render chiropractic services.

7 PAYEE INFORMATION

This area records the name and address of any persons or entities authorized to receive payments on behalf of the provider. Each potential payee is assigned a single-digit **PAYEE CODE**, which is to be used on the claim form to designate the payee to whom the warrant is to be paid.

If no payee number is designated on a claim form, but multiple payees are shown on the Provider Information Sheet, the claim will be rejected.

PAYEE ID NUMBER is a sixteen-digit identification number assigned to each payee to whom warrants may be issued. A portion of this number is used for tax reporting purposes, therefore no payments can be made to a payee unless the number is on file. Immediately following this number is the effective date when payment may be made to each payee on behalf of the provider.

The **MEDICARE/PIN** or the **DMERC #** is the number assigned to the payee by the Medicare Carrier to cross-over Medicare billable services. The **PIN** is the number assigned by Medicare to a provider within a group practice, if applicable.

8 SIGNATURE

The provider is required to affix an original signature when submitting changes to the Department of Public Aid.

APPENDIX B-3a

Reduced Facsimile of Provider Information Sheet

STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID

MEDICAID SYSTEM (MMIS)
PROVIDER SUBSYSTEM
REPORT ID: A2741KD1
SEQUENCE: PROVIDER TYPE
PROVIDER NAME

PROVIDER INFORMATION SHEET

RUN DATE: 06/02/02
RUN TIME: 11:47:05
MAINT DATE: 06/02/02
PAGE: 84

1 --PROVIDER KEY-- 000011111001

2 PROVIDER NAME AND ADDRESS
John Smith
1421 MY STREET
ANYTOWN, IL 62000

3 PROVIDER TYPE: 014 - Chiropractor
ORGANIZATION TYPE: 01 - Individual Pract
ENROLLMENT STATUS B - ACTIV NOCST BEGIN 01/15/02END ACTIVE
EXCEPTION INDICATOR - NO EXCEPT BEGIN END
AGR: YES BILL:NONE

PROVIDER GENDER:
COUNTY 089-SCOTT
TELEPHONE NUMBER: (217)742-1234
D.E.A.#:

CERTIFIC/LICENSE NUM -000011111 ENDING 03/31/02
LAST TRANSACTION ADD AS OF 05/21/02
UPIN #:
S.S. #:

4 RE-ENROLLMENT INDICATOR: N DATE: 11/15/86

5 HEALTHY KIDS/HEALTHY MOMS INFORMATION: BEGIN DATE: / /

| COS | ELIGIBILITY CATEGORY OF SERVICE | BEG DATE | COS | ELIGIBILITY CATEGORY OF SERVICE | BEG DATE | ELIG | TERMINATION |
|-----|---------------------------------|----------|-----|---------------------------------|----------|------|-------------|
| 005 | Chiropractic Services | 06/15/02 | | | | | REASON |

6 PAYEE

| CODE | PAYEE NAME | PAYEE STREET | PAYEE CITY | ST | ZIP | PAYEE ID NUMBER | DMERC# | EFF DATE |
|------|------------|----------------|------------|----|-------|--------------------|--------|----------|
| 1 | John Smith | 1421 MY STREET | ANYTOWN | IL | 62000 | 001010101-62000-01 | | 11/15/86 |

7 DBA:
MEDICARE/PIN: 999999

VENDOR ID: 01

8 ***** PLEASE NOTE: *****
* ORIGINAL SIGNATURE OF PROVIDER REQUIRED WHEN SUBMITTING CHANGES VIA THIS FORM: DATE _____ X _____